106TH CONGRESS
2D SESSION

S. 2935

To amend the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and the Public Health Service Act to increase Americans' access to long term health care, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 26, 2000

Mr. GRAHAM (for himself, Mr. GRASSLEY, Ms. MIKULSKI, Mr. BAYH, Mr. BREAUX, Ms. COLLINS, and Mr. AKAKA) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and the Public Health Service Act to increase Americans' access to long term health care, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Omnibus Long-term Care Act of 2000''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—LONG TERM CARE

Subtitle A—Tax Incentives

SEC. 101. TREATMENT OF PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 222 as section 223 and by inserting after section 221 the following new section:

"SEC. 222. PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount of eligible long-term care premiums (as defined in section 213(d)(10)) paid during the taxable year for coverage for the taxpayer, his spouse, and dependents under a qualified long-term care insurance contract (as defined in section 7702B(b)).

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a)—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the applicable percentage shall be determined in accordance with the following table based on the number of years of continuous coverage (as of the close of the taxable year) of the

individual under any qualified long-term care insurance contracts (as defined in section 7702B(b)):

"If the number of years of continuous coverage is—	The applicable long-term care percentage is—
Less than 1	60
At least 1 but less than 2	70
At least 2 but less than 3	80
At least 3 but less than 4	90
At least 4	100.

''(2) SPECIAL RULES FOR INDIVIDUALS WHO HAVE ATTAINED AGE 55.—In the case of an individual who has attained age 55 as of the close of the taxable year, the following table shall be substituted for the table in paragraph (1).

"If the number of years of continuous coverage is—	The applicable long-term care percentage is—
Less than 1	70
At least 1 but less than 2	85
At least 2	100.

''(3) ONLY COVERAGE AFTER 2000 TAKEN INTO ACCOUNT.—Only coverage for periods after December 31, 2000, shall be taken into account under this subsection.

''(4) CONTINUOUS COVERAGE.—An individual shall not fail to be treated as having continuous coverage if the aggregate breaks in coverage during any 1-year period are less than 60 days.

''(c) COORDINATION WITH OTHER DEDUCTIONS.—Any amount paid by a taxpayer for any qualified long-term care insurance contract to which subsection (a) applies shall not be taken into account in computing the

amount allowable to the taxpayer as a deduction under section 162(l) or 213(a).''

(b) CONTINGENT NONFORFEITURE REQUIREMENTS ADDED TO CONSUMER PROTECTION PROVISIONS.—

(1) Section 7702B(g)(2)(A)(i) of the Internal Revenue Code of 1986 (relating to model regulation) is amended by adding at the end the following new subclause:

''(XII) Section 23 (relating to contingent nonforfeiture benefits), if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).''

(2) Section 7702B(g)(2)(A)(ii) of such Code (relating to model Act) is amended by adding at the end the following new subclause:

''(III) Section 8 (relating to contingent nonforfeiture benefits), if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).''

(c) REFERENCE TO NAIC MODEL ACT UPDATED.—Section 7702B(g)(2)(B)(i) of the Internal Revenue Code of 1986 (relating to model provisions) is amended by striking ''January 1993'' and inserting ''January 1999''.

(d) LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by inserting before the period at the end ''; except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract''.

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by an employer to accident and health plans) is amended by striking subsection (c).

(e) CONFORMING AMENDMENTS.—

(1) Section 62(a) of the Internal Revenue Code of 1986 is amended by inserting after paragraph (17) the following new item:

''(18) PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—The deduction allowed by section 222.''

(2) Section 7702B(g)(2)(A)(i) of such Code, as amended by subsection (b)(1), is amended by striking ''7A'' both places it appears, ''7B'', ''7C'', ''7D'', ''7E'', ''8'', ''9'', ''9F'', ''10'', ''11'', ''12'', and ''23'' the first place it appears and inserting ''6A'', ''6B'', ''6C'', ''6D'', ''6E'', ''7'', ''8'', ''8F'', ''9'', ''10'', ''11'', and ''22'', respectively.

(3) Section 4980C(c)(1)(A) of such Code is amended by striking ''13'', ''14'', ''20'', ''21'', ''21C(1)'', ''21C(6)'', ''22'', ''24'', and ''25'' and inserting ''12'', ''13'', ''19'', ''20C(1)'', ''20C(6)'', ''21'', ''25'', and ''26'', respectively.

(4) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 222. Premiums on qualified long-term care insurance contracts.
''Sec. 223. Cross reference.''

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after December 31, 2000.

(2) CONSUMER PROTECTION PROVISIONS.—The amendments made by subsections (b), (c), (e)(2), and (e)(3) shall apply to policies issued after the

date which is 1 year after the date of the enactment of this Act.

(3) CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—The amendments made by subsection (c) shall apply to taxable years beginning after December 31, 2001.

SEC. 102. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25A the following new section:

"SEC. 25B. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable credit amount multiplied by the number of applicable individuals with respect to whom the taxpayer is an eligible caregiver for the taxable year.

''(2) APPLICABLE CREDIT AMOUNT.—For purposes of paragraph (1), the applicable credit amount

shall be determined in accordance with the following table:

"For taxable years beginning in calendar year—	The applicable credit amount is—
2001	$1,000
2002	1,500
2003	2,000
2004	2,500
2005 or thereafter	3,000.

"(b) LIMITATION BASED ON ADJUSTED GROSS INCOME.—

"(1) IN GENERAL.—The amount of the credit allowable under subsection (a) shall be reduced (but not below zero) by $100 for each $1,000 (or fraction thereof) by which the taxpayer's modified adjusted gross income exceeds the threshold amount. For purposes of the preceding sentence, the term 'modified adjusted gross income' means adjusted gross income increased by any amount excluded from gross income under section 911, 931, or 933.

"(2) THRESHOLD AMOUNT.—For purposes of paragraph (1), the term 'threshold amount' means—

"(A) $150,000 in the case of a joint return, and

"(B) $75,000 in any other case.

"(3) INDEXING.—In the case of any taxable year beginning in a calendar year after 2001, each dollar amount contained in paragraph (2) shall be increased by an amount equal to the product of—

''(A) such dollar amount, and

''(B) the medical care cost adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins, determined by substituting 'August of 2000' for 'August of 1996' in subclause (II) thereof.

If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(c) DEFINITIONS.—For purposes of this section—

''(1) APPLICABLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'applicable individual' means, with respect to any taxable year, any individual who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1861(r)(1) of the Social Security Act) as being an individual with long-term care needs described in subparagraph (B) for a period—

''(i) which is at least 180 consecutive days, and

''(ii) a portion of which occurs within the taxable year.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the 39½ month period ending on such due date (or such other period as the Secretary prescribes) a physician (as so defined) has certified that such individual meets such requirements.

''(B) INDIVIDUALS WITH LONG-TERM CARE NEEDS.—An individual is described in this subparagraph if the individual meets any of the following requirements:

''(i) The individual is at least 6 years of age and—

''(I) is unable to perform (without substantial assistance from another individual) at least 3 activities of daily living (as defined in section 7702B(c)(2)(B)) due to a loss of functional capacity, or

''(II) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to preform, without reminding or cuing assistance, at least 1 activity of

daily living (as so defined) or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

''(ii) The individual is at least 2 but not 6 years of age and is unable due to a loss of functional capacity to perform (without substantial assistance from another individual) at least 2 of the following activities: eating, transferring, or mobility.

''(iii) The individual is under 2 years of age and requires specific durable medical equipment by reason of a severe health condition or requires a skilled practitioner trained to address the individual's condition to be available if the individual's parents or guardians are absent.

''(2) ELIGIBLE CAREGIVER.—

''(A) IN GENERAL.—A taxpayer shall be treated as an eligible caregiver for any taxable year with respect to the following individuals:

''(i) The taxpayer.

''(ii) The taxpayer's spouse.

"(iii) An individual with respect to whom the taxpayer is allowed a deduction under section 151 for the taxable year.

"(iv) An individual who would be described in clause (iii) for the taxable year if section 151(c)(1)(A) were applied by substituting for the exemption amount an amount equal to the sum of the exemption amount, the standard deduction under section 63(c)(2)(C), and any additional standard deduction under section 63(c)(3) which would be applicable to the individual if clause (iii) applied.

"(v) An individual who would be described in clause (iii) for the taxable year if—

"(I) the requirements of clause (iv) are met with respect to the individual, and

"(II) the requirements of subparagraph (B) are met with respect to the individual in lieu of the support test of section 152(a).

"(B) RESIDENCY TEST.—The requirements of this subparagraph are met if an indi-

vidual has as his principal place of abode the home of the taxpayer and—

''(i) in the case of an individual who is an ancestor or descendant of the taxpayer or the taxpayer's spouse, is a member of the taxpayer's household for over half the taxable year, or

''(ii) in the case of any other individual, is a member of the taxpayer's household for the entire taxable year.

''(C) SPECIAL RULES WHERE MORE THAN 1 ELIGIBLE CAREGIVER.—

''(i) IN GENERAL.—If more than 1 individual is an eligible caregiver with respect to the same applicable individual for taxable years ending with or within the same calendar year, a taxpayer shall be treated as the eligible caregiver if each such individual (other than the taxpayer) files a written declaration (in such form and manner as the Secretary may prescribe) that such individual will not claim such applicable individual for the credit under this section.

''(ii) NO AGREEMENT.—If each individual required under clause (i) to file a written declaration under clause (i) does not do so, the individual with the highest modified adjusted gross income (as defined in section 32(c)(5)) shall be treated as the eligible caregiver.

''(iii) MARRIED INDIVIDUALS FILING SEPARATELY.—In the case of married individuals filing separately, the determination under this subparagraph as to whether the husband or wife is the eligible caregiver shall be made under the rules of clause (ii) (whether or not one of them has filed a written declaration under clause (i)).

''(d) IDENTIFICATION REQUIREMENT.—No credit shall be allowed under this section to a taxpayer with respect to any applicable individual unless the taxpayer includes the name and taxpayer identification number of such individual, and the identification number of the physician certifying such individual, on the return of tax for the taxable year.

''(e) TAXABLE YEAR MUST BE FULL TAXABLE YEAR.—Except in the case of a taxable year closed by reason of the death of the taxpayer, no credit shall be allow-

able under this section in the case of a taxable year covering a period of less than 12 months.''

(b) CONFORMING AMENDMENTS.—

(1) Section 6213(g)(2) of the Internal Revenue Code of 1986 is amended by striking ''and'' at the end of subparagraph (K), by striking the period at the end of subparagraph (L) and inserting '', and'', and by inserting after subparagraph (L) the following new subparagraph:

''(M) an omission of a correct TIN or physician identification required under section 25B(d) (relating to credit for taxpayers with long-term care needs) to be included on a return.''

(2) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25A the following new item:

''Sec. 25B. Credit for taxpayers with long-term care needs.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

Subtitle B—Federal Employees and Uniformed Services Group Long-Term Care Insurance

SEC. 111. SHORT TITLE.

This subtitle may be cited as the ''Long-Term Care Security Act''.

SEC. 112. LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Subpart G of part III of title 5, United States Code, is amended by adding at the end the following:

''CHAPTER 90—LONG-TERM CARE INSURANCE

''§ 9001. Definitions

For purposes of this chapter:

''(1) EMPLOYEE.—The term 'employee' means—

''(A) an employee as defined by section 8901(1); and

''(B) an individual described in section 2105(e);

but does not include an individual employed by the government of the District of Columbia.

''(2) ANNUITANT.—The term 'annuitant' has the meaning such term would have under paragraph (3) of section 8901 if, for purposes of such paragraph, the term 'employee' were considered to have the meaning given to it under paragraph (1) of this subsection.

''(3) MEMBER OF THE UNIFORMED SERVICES.—The term 'member of the uniformed services' means a member of the uniformed services, other than a retired member of the uniformed services.

''(4) RETIRED MEMBER OF THE UNIFORMED SERVICES.—The term 'retired member of the uniformed services' means a member or former member of the uniformed services entitled to retired or retainer pay.

''(5) QUALIFIED RELATIVE.—The term 'qualified relative' means each of the following:

''(A) The spouse of an individual described in paragraph (1), (2), (3), or (4).

''(B) A parent, stepparent, or parent-in-law of an individual described in paragraph (1) or (3).

''(C) A child (including an adopted child, a stepchild, or, to the extent the Office of Personnel Management by regulation provides, a foster child) of an individual described in paragraph (1), (2), (3), or (4), if such child is at least 18 years of age.

''(D) An individual having such other relationship to an individual described in paragraph (1), (2), (3), or (4) as the Office may by regulation prescribe.

''(6) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' refers to an individual described in paragraph (1), (2), (3), (4), or (5).

''(7) QUALIFIED CARRIER.—The term 'qualified carrier' means an insurance company (or consortium of insurance companies) that is licensed to issue long-term care insurance in all States, taking any subsidiaries of such a company into account (and, in the case of a consortium, considering the member companies and any subsidiaries thereof, collectively).

''(8) STATE.—The term 'State' includes the District of Columbia.

''(9) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—The term 'qualified long-term care insurance contract' has the meaning given such term

by section 7702B of the Internal Revenue Code of 1986.

''(10) APPROPRIATE SECRETARY.—The term 'appropriate Secretary' means—

''(A) except as otherwise provided in this paragraph, the Secretary of Defense;

''(B) with respect to the Coast Guard when it is not operating as a service of the Navy, the Secretary of Transportation;

''(C) with respect to the commissioned corps of the National Oceanic and Atmospheric Administration, the Secretary of Commerce; and

''(D) with respect to the commissioned corps of the Public Health Service, the Secretary of Health and Human Services.

''§ 9002. Availability of insurance

''(a) IN GENERAL.—The Office of Personnel Management shall establish and, in consultation with the appropriate Secretaries, administer a program through which an individual described in paragraph (1), (2), (3), (4), or (5) of section 9001 may obtain long-term care insurance coverage under this chapter for such individual.

''(b) GENERAL REQUIREMENTS.—Long-term care insurance may not be offered under this chapter unless—

''(1) the only coverage provided is under qualified long-term care insurance contracts; and

''(2) each insurance contract under which any such coverage is provided is issued by a qualified carrier.

''(c) DOCUMENTATION REQUIREMENT.—As a condition for obtaining long-term care insurance coverage under this chapter based on one's status as a qualified relative, an applicant shall provide documentation to demonstrate the relationship, as prescribed by the Office.

''(d) UNDERWRITING STANDARDS.—

''(1) DISQUALIFYING CONDITION.—Nothing in this chapter shall be considered to require that long-term care insurance coverage be made available in the case of any individual who would be eligible for benefits immediately.

''(2) SPOUSAL PARITY.—For the purpose of underwriting standards, a spouse of an individual described in paragraph (1), (2), (3), or (4) of section 9001 shall, as nearly as practicable, be treated like that individual.

''(3) GUARANTEED ISSUE.—Nothing in this chapter shall be considered to require that long-term care insurance coverage be guaranteed to an eligible individual.

''(4) REQUIREMENT THAT CONTRACT BE FULLY INSURED.—In addition to the requirements otherwise applicable under section 9001(9), in order to be considered a qualified long-term care insurance contract for purposes of this chapter, a contract shall be fully insured, whether through reinsurance with other companies or otherwise.

''(5) HIGHER STANDARDS ALLOWABLE.—Nothing in this chapter shall, in the case of an individual applying for long-term care insurance coverage under this chapter after the expiration of such individual's first opportunity to enroll, preclude the application of underwriting standards more stringent than those that would have applied if that opportunity had not yet expired.

''(e) GUARANTEED RENEWABILITY.—The benefits and coverage made available to eligible individuals under any insurance contract under this chapter shall be guaranteed renewable (as defined by section 7A(2) of the model regulations described in section 7702B(g)(2) of the Internal Revenue Code of 1986), including the right to have insurance remain in effect so long as premiums continue to be timely made. However, the authority to revise premiums under this chapter shall be available only on a class

basis and only to the extent otherwise allowable under section 9003(b).

"§ 9003. Contracting authority

''(a) IN GENERAL.—Without regard to section 3709 of the Revised Statutes (41 U.S.C. 5) or any other statute requiring competitive bidding, the Office of Personnel Management shall contract with 1 or more qualified carriers for a policy or policies of long-term care insurance. The Office shall ensure that each resulting contract (in this chapter referred to as a 'master contract') is awarded on the basis of contractor qualifications, price, and reasonable competition.

''(b) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Each master contract under this chapter shall contain—

''(A) a detailed statement of the benefits offered (including any maximums, limitations, exclusions, and other definitions of benefits);

''(B) the premiums charged (including any limitations or other conditions on their subsequent adjustment);

''(C) the terms of the enrollment period; and

''(D) such other terms and conditions as may be mutually agreed to by the Office and

the carrier involved, consistent with the requirements of this chapter.

''(2) PREMIUMS.—Premiums charged under each master contract entered into under this section shall reasonably and equitably reflect the cost of the benefits provided, as determined by the Office. The premiums shall not be adjusted during the term of the contract unless mutually agreed to by the Office and the carrier.

''(3) NONRENEWABILITY.—Master contracts under this chapter may not be made automatically renewable.

''(c) PAYMENT OF REQUIRED BENEFITS; DISPUTE RESOLUTION.—

''(1) IN GENERAL.—Each master contract under this chapter shall require the carrier to agree—

''(A) to provide payments or benefits to an eligible individual if such individual is entitled to such payments or benefits under the terms of the contract; and

''(B) with respect to disputes regarding claims for payments or benefits under the terms of the contract—

''(i) to establish internal procedures designed to expeditiously resolve such disputes; and

''(ii) to establish, for disputes not resolved through procedures under clause (i), procedures for 1 or more alternative means of dispute resolution involving independent third-party review under appropriate circumstances by entities mutually acceptable to the Office and the carrier.

''(2) ELIGIBILITY.—A carrier's determination as to whether or not a particular individual is eligible to obtain long-term care insurance coverage under this chapter shall be subject to review only to the extent and in the manner provided in the applicable master contract.

''(3) OTHER CLAIMS.—For purposes of applying the Contract Disputes Act of 1978 to disputes arising under this chapter between a carrier and the Office—

''(A) the agency board having jurisdiction to decide an appeal relative to such a dispute shall be such board of contract appeals as the Director of the Office of Personnel Management shall specify in writing (after appropriate ar-

rangements, as described in section 8(c) of such Act); and

''(B) the district courts of the United States shall have original jurisdiction, concurrent with the United States Court of Federal Claims, of any action described in section 10(a)(1) of such Act relative to such a dispute.

''(4) RULE OF CONSTRUCTION.—Nothing in this chapter shall be considered to grant authority for the Office or a third-party reviewer to change the terms of any contract under this chapter.

''(d) DURATION.—

''(1) IN GENERAL.—Each master contract under this chapter shall be for a term of 7 years, unless terminated earlier by the Office in accordance with the terms of such contract. However, the rights and responsibilities of the enrolled individual, the insurer, and the Office (or duly designated third-party administrator) under such contract shall continue with respect to such individual until the termination of coverage of the enrolled individual or the effective date of a successor contract.

''(2) EXCEPTION.—

''(A) SHORTER DURATION.—In the case of a master contract entered into before the end of

the period described in subparagraph (B), paragraph (1) shall be applied by substituting 'ending on the last day of the 7-year period described in paragraph (2)(B)' for 'of 7 years'.

"(B) DEFINITION.—The period described in this subparagraph is the 7-year period beginning on the earliest date as of which any long-term care insurance coverage under this chapter becomes effective.

"(3) CONGRESSIONAL NOTIFICATION.—No later than 180 days after receiving the second report required under section 9006(c), the President (or his designee) shall submit to the Committees on Government Reform and on Armed Services of the House of Representatives and the Committees on Governmental Affairs and on Armed Services of the Senate, a written recommendation as to whether the program under this chapter should be continued without modification, terminated, or restructured. During the 180-day period following the date on which the President (or his designee) submits the recommendation required under the preceding sentence, the Office of Personnel Management may not take any steps to rebid or otherwise contract for any coverage to be available at any time following the expi-

ration of the 7-year period described in paragraph (2)(B).

''(4) FULL PORTABILITY.—Each master contract under this chapter shall include such provisions as may be necessary to ensure that, once an individual becomes duly enrolled, long-term care insurance coverage obtained by such individual pursuant to that enrollment shall not be terminated due to any change in status (such as separation from Government service or the uniformed services) or ceasing to meet the requirements for being considered a qualified relative (whether as a result of dissolution of marriage or otherwise).

''§ 9004. Financing

''(a) IN GENERAL.—Each eligible individual obtaining long-term care insurance coverage under this chapter shall be responsible for 100 percent of the premiums for such coverage.

''(b) WITHHOLDINGS.—

''(1) IN GENERAL.—The amount necessary to pay the premiums for enrollment may—

''(A) in the case of an employee, be withheld from the pay of such employee;

''(B) in the case of an annuitant, be withheld from the annuity of such annuitant;

"(C) in the case of a member of the uniformed services described in section 9001(3), be withheld from the basic pay of such member; and

"(D) in the case of a retired member of the uniformed services described in section 9001(4), be withheld from the retired pay or retainer pay payable to such member.

"(2) VOLUNTARY WITHHOLDINGS FOR QUALIFIED RELATIVES.—Withholdings to pay the premiums for enrollment of a qualified relative may, upon election of the appropriate eligible individual (described in section 9001 (1) through (4)), be withheld under paragraph (1) to the same extent and in the same manner as if enrollment were for such individual.

"(c) DIRECT PAYMENTS.—All amounts withheld under this section shall be paid directly to the carrier.

"(d) OTHER FORMS OF PAYMENT.—Any enrollee who does not elect to have premiums withheld under subsection (b) or whose pay, annuity, or retired or retainer pay (as referred to in subsection (b)(1)) is insufficient to cover the withholding required for enrollment (or who is not receiving any regular amounts from the Government, as referred to in subsection (b)(1), from which any such

withholdings may be made, and whose premiums are not otherwise being provided for under subsection (b)(2)) shall pay an amount equal to the full amount of those charges directly to the carrier.

''(e) SEPARATE ACCOUNTING REQUIREMENT.—Each carrier participating under this chapter shall maintain records that permit it to account for all amounts received under this chapter (including investment earnings on those amounts) separate and apart from all other funds.

''(f) REIMBURSEMENTS.—

''(1) REASONABLE INITIAL COSTS.—

''(A) IN GENERAL.—The Employees' Life Insurance Fund is available, without fiscal year limitation, for reasonable expenses incurred by the Office of Personnel Management in administering this chapter before the start of the 7-year period described in section 9003(d)(2)(B), including reasonable implementation costs.

''(B) REIMBURSEMENT REQUIREMENT.—Such Fund shall be reimbursed, before the end of the first year of that 7-year period, for all amounts obligated or expended under subparagraph (A) (including lost investment income). Such reimbursement shall be made by carriers, on a pro rata basis, in accordance with appro-

priate provisions which shall be included in master contracts under this chapter.

''(2) SUBSEQUENT COSTS.—

''(A) IN GENERAL.—There is established in the Employees' Life Insurance Fund a Long-Term Care Administrative Account, which shall be available to the Office, without fiscal year limitation, to defray reasonable expenses incurred by the Office in administering this chapter after the start of the 7-year period described in section 9003(d)(2)(B).

''(B) REIMBURSEMENT REQUIREMENT.—Each master contract under this chapter shall include appropriate provisions under which the carrier involved shall, during each year, make such periodic contributions to the Long-Term Care Administrative Account as necessary to ensure that the reasonable anticipated expenses of the Office in administering this chapter during such year (adjusted to reconcile for any earlier overestimates or underestimates under this subparagraph) are defrayed.

''§ 9005. Preemption

''The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or

benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued under such law, which relates to long-term care insurance or contracts.

"§ 9006. Studies, reports, and audits

''(a) PROVISIONS RELATING TO CARRIERS.—Each master contract under this chapter shall contain provisions requiring the carrier—

''(1) to furnish such reasonable reports as the Office of Personnel Management determines to be necessary to enable it to carry out its functions under this chapter; and

''(2) to permit the Office and representatives of the General Accounting Office to examine such records of the carrier as may be necessary to carry out the purposes of this chapter.

''(b) PROVISIONS RELATING TO FEDERAL AGENCIES.—Each Federal agency shall keep such records, make such certifications, and furnish the Office, the carrier, or both, with such information and reports as the Office may require.

''(c) REPORTS BY THE GENERAL ACCOUNTING OFFICE.—The General Accounting Office shall prepare and submit to the President, the Office of Personnel Management, and each House of Congress, before the end of the

third and fifth years during which the program under this chapter is in effect, a written report evaluating such program. Each such report shall include an analysis of the competitiveness of the program, as compared to both group and individual coverage generally available to individuals in the private insurance market. The Office shall cooperate with the General Accounting Office to provide periodic evaluations of the program.

"§ 9007. Jurisdiction of courts

''The district courts of the United States have original jurisdiction of a civil action or claim described in paragraph (1) or (2) of section 9003(c), after such administrative remedies as required under such paragraph (1) or (2) (as applicable) have been exhausted, but only to the extent judicial review is not precluded by any dispute resolution or other remedy under this chapter.

"§ 9008. Administrative functions

''(a) IN GENERAL.—The Office of Personnel Management shall prescribe regulations necessary to carry out this chapter.

''(b) ENROLLMENT PERIODS.—The Office shall provide for periodic coordinated enrollment, promotion, and education efforts in consultation with the carriers.

''(c) CONSULTATION.—Any regulations necessary to effect the application and operation of this chapter with

respect to an eligible individual described in paragraph (3) or (4) of section 9001, or a qualified relative of such an individual, shall be prescribed by the Office in consultation with the appropriate Secretary.

''(d) INFORMED DECISIONMAKING.—The Office shall ensure that each eligible individual applying for long-term care insurance under this chapter is furnished the information necessary to enable that individual to evaluate the advantages and disadvantages of obtaining long-term care insurance under this chapter, including the following:

''(1) The principal long-term care benefits and coverage available under this chapter, and how those benefits and coverage compare to the range of long-term care benefits and coverage otherwise generally available.

''(2) Representative examples of the cost of long-term care, and the sufficiency of the benefits available under this chapter relative to those costs. The information under this paragraph shall also include—

''(A) the projected effect of inflation on the value of those benefits; and

''(B) a comparison of the inflation-adjusted value of those benefits to the projected future costs of long-term care.

''(3) Any rights individuals under this chapter may have to cancel coverage, and to receive a total or partial refund of premiums. The information under this paragraph shall also include—

''(A) the projected number or percentage of individuals likely to fail to maintain their coverage (determined based on lapse rates experienced under similar group long-term care insurance programs and, when available, this chapter); and

''(B)(i) a summary description of how and when premiums for long-term care insurance under this chapter may be raised;

''(ii) the premium history during the last 10 years for each qualified carrier offering long-term care insurance under this chapter; and

''(iii) if cost increases are anticipated, the projected premiums for a typical insured individual at various ages.

''(4) The advantages and disadvantages of long-term care insurance generally, relative to other means of accumulating or otherwise acquiring the assets that may be needed to meet the costs of long-term care, such as through tax-qualified retirement programs or other investment vehicles.

"§ 9009. Cost accounting standards

''The cost accounting standards issued under section 26(f) of the Office of Federal Procurement Policy Act (41 U.S.C. 422(f)) shall not apply with respect to a long-term care insurance contract under this chapter.''.

(b) CONFORMING AMENDMENT.—The analysis for part III of title 5, United States Code, is amended by adding at the end of subpart G the following:

SEC. 113. EFFECTIVE DATE.

The Office of Personnel Management shall take such measures as may be necessary to ensure that long-term care insurance coverage under title 5, United States Code, as amended by this subtitle, may be obtained in time to take effect not later than the first day of the first applicable pay period of the first fiscal year which begins after the end of the 18-month period beginning on the date of enactment of this Act.

Subtitle C—Seniors' Access to Continuing Care

SEC. 121. SHORT TITLE.

This subtitle may be cited as the ''Seniors' Access to Continuing Care Act of 2000''.

SEC. 122. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

"SEC. 714. ENSURING CHOICE FOR CONTINUING CARE.

''(a) IN GENERAL.—With respect to health insurance coverage provided to participants or beneficiaries through a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, such plan or issuer may not deny coverage for services provided to such participant or beneficiary by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the participant or beneficiary resided prior to a hospitalization, regardless of whether such organization is under contract with such community or facility if the requirements described in subsection (b) are met.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the service involved is a service for which the managed care organization involved would be required to provide or pay for under its contract with the participant or beneficiary if the continuing care

retirement community, skilled nursing facility, or other qualified facility were under contract with the organization;

''(2) the participant or beneficiary involved—

''(A) resided in the continuing care retirement community, skilled nursing facility, or other qualified facility prior to being hospitalized;

''(B) had a contractual or other right to return to the facility after hospitalization; and

''(C) elects to return to the facility after hospitalization, whether or not the residence of the participant or beneficiary after returning from the hospital is the same part of the facility in which the beneficiary resided prior to hospitalization;

''(3) the continuing care retirement community, skilled nursing facility, or other qualified facility has the capacity to provide the services the participant or beneficiary needs;

''(4) the continuing care retirement community, skilled nursing facility, or other qualified facility is willing to accept substantially similar payment under the same terms and conditions that apply to simi-

larly situated health care facility providers under contract with the organization involved.

''(c) SERVICES TO PREVENT HOSPITALIZATION.—A group health plan or health insurance issuer to which this section applies may not deny payment for a skilled nursing service provided to a participant or beneficiary by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the participant or beneficiary resides, without a preceding hospital stay, regardless of whether the organization is under contract with such community or facility, if—

''(1) the plan or issuer has determined that the service is necessary to prevent the hospitalization of the participant or beneficiary; and

''(2) the service to prevent hospitalization is provided as an additional benefit as described in section 417.594 of title 42, Code of Federal Regulations, and would otherwise be covered as provided for in subsection (b)(1).

''(d) RIGHTS OF SPOUSES.—A group health plan or health insurance issuer to which this section applies shall not deny payment for services provided by a skilled nursing facility for the care of a participant or beneficiary, regardless of whether the plan or issuer is under contract with such facility, if the spouse of the participant or bene-

ficiary is already a resident of such facility and the requirements described in subsection (b) are met.

''(e) EXCEPTIONS.—Subsection (a) shall not apply—

''(1) where the attending acute care provider and the participant or beneficiary (or a designated representative of the participant or beneficiary where the participant or beneficiary is physically or mentally incapable of making an election under this paragraph) do not elect to pursue a course of treatment necessitating continuing care; or

''(2) unless the community or facility involved—

''(A) meets all applicable licensing and certification requirements of the State in which it is located; and

''(B) agrees to reimbursement for the care of the participant or beneficiary at a rate similar to the rate negotiated by the managed care organization with similar providers of care for similar services.

''(f) PROHIBITIONS.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage with a managed care organization under the plan, solely for

the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to enrollees to encourage such enrollees to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending physician because such physician provided care to a participant or beneficiary in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to an attending physician to induce such physician to provide care to a participant or beneficiary in a manner inconsistent with this section.

''(g) RULES OF CONSTRUCTION.—

''(1) HMO NOT OFFERING BENEFITS.—This section shall not apply with respect to any managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, that does not provide benefits for stays in a continuing care retirement community, skilled nursing facility, or other qualified facility.

''(2) COST-SHARING.—Nothing in this section shall be construed as preventing a managed care or-

ganization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for care in a continuing care facility.

''(h) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

''(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage to the extent that a State law (as defined in section 2723(d)(1) of the Public Health Service Act) applies to such coverage and is described in any of the following subparagraphs:

''(A) Such State law requires such coverage to provide for referral to a continuing care retirement community, skilled nursing facility, or other qualified facility in a manner that is more protective of participants or beneficiaries than the provisions of this section.

''(B) Such State law expands the range of services or facilities covered under this section and is otherwise more protective of the rights of participants or beneficiaries than the provisions of this section.

''(2) CONSTRUCTION.—Section 731(a)(1) shall not be construed to provide that any requirement of this section applies with respect to health insurance coverage, to the extent that a State law described in paragraph (1) applies to such coverage.

''(i) PENALTIES.—A participant or beneficiary may enforce the provisions of this section in an appropriate Federal district court. An action for injunctive relief or damages may be commenced on behalf of the participant or beneficiary by the participant's or beneficiary's legal representative. The court may award reasonable attorneys' fees to the prevailing party. If a beneficiary dies before conclusion of an action under this section, the action may be maintained by a representative of the participant's or beneficiary's estate.

''(j) DEFINITIONS.—In this section:

''(1) ATTENDING ACUTE CARE PROVIDER.—The term 'attending acute care provider' means anyone licensed or certified under State law to provide health care services who is operating within the scope of such license and who is primarily responsible for the care of the enrollee.

''(2) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means an organization that provides or ar-

ranges for the provision of housing and health-related services to an older person under an agreement effective for the life of the person or for a specified period greater than 1 year.

''(3) MANAGED CARE ORGANIZATION.—The term 'managed care organization' means an organization that provides comprehensive health services to participants or beneficiaries, directly or under contract or other agreement, on a prepayment basis to such individuals. For purposes of this section, the following shall be considered as managed care organizations:

''(A) A Medicare+Choice plan authorized under section 1851(a) of the Social Security Act (42 U.S.C. 1395w–21(a)).

''(B) Any other entity that manages the cost, utilization, and delivery of health care through the use of predetermined periodic payments to health care providers employed by or under contract or other agreement, directly or indirectly, with the entity.

''(4) OTHER QUALIFIED FACILITY.—The term 'other qualified facility' means any facility that can provide the services required by the participant or beneficiary consistent with State and Federal law.

''(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' means a facility that meets the requirements of section 1819 of the Social Security Act (42 U.S.C. 1395i–3).''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the items relating to subpart B of part 7 of subtitle B of title I the following new item:

''Sec. 714. Ensuring choice for continuing care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2001.

SEC. 123. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following new section:

''SEC. 2707. ENSURING CHOICE FOR CONTINUING CARE.

''(a) IN GENERAL.—With respect to health insurance coverage provided to enrollees through a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, such plan or issuer may not deny coverage for services provided to such en-

rollee by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the enrollee resided prior to a hospitalization, regardless of whether such organization is under contract with such community or facility if the requirements described in subsection (b) are met.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the service involved is a service for which the managed care organization involved would be required to provide or pay for under its contract with the enrollee if the continuing care retirement community, skilled nursing facility, or other qualified facility were under contract with the organization;

''(2) the enrollee involved—

''(A) resided in the continuing care retirement community, skilled nursing facility, or other qualified facility prior to being hospitalized;

''(B) had a contractual or other right to return to the facility after hospitalization; and

''(C) elects to return to the facility after hospitalization, whether or not the residence of the enrollee after returning from the hospital is

the same part of the facility in which the beneficiary resided prior to hospitalization;

''(3) the continuing care retirement community, skilled nursing facility, or other qualified facility has the capacity to provide the services the enrollee needs;

''(4) the continuing care retirement community, skilled nursing facility, or other qualified facility is willing to accept substantially similar payment under the same terms and conditions that apply to similarly situated health care facility providers under contract with the organization involved.

''(c) SERVICES TO PREVENT HOSPITALIZATION.—A group health plan or health insurance issuer to which this section applies may not deny payment for a skilled nursing service provided to an enrollee by a continuing care retirement community, skilled nursing facility, or other qualified facility in which the enrollee resides, without a preceding hospital stay, regardless of whether the plan or issuer is under contract with such community or facility, if—

''(1) the plan or issuer has determined that the service is necessary to prevent the hospitalization of the enrollee; and

''(2) the service to prevent hospitalization is provided as an additional benefit as described in section 417.594 of title 42, Code of Federal Regulations, and would be covered as provided for in subsection (b)(1).

''(d) RIGHTS OF SPOUSES.—A group health plan or health insurance issuer to which this section applies shall not deny payment for services provided by a skilled nursing facility for the care of an enrollee, regardless of whether the plan or issuer is under contract with such facility, if the spouse of the enrollee is already a resident of such facility and the requirements described in subsection (b) are met.

''(e) EXCEPTIONS.—Subsection (a) shall not apply—

''(1) where the attending acute care provider and the enrollee (or a designated representative of the enrollee where the enrollee is physically or mentally incapable of making an election under this paragraph) do not elect to pursue a course of treatment necessitating continuing care; or

''(2) unless the community or facility involved—

''(A) meets all applicable licensing and certification requirements of the State in which it is located; and

''(B) agrees to reimbursement for the care of the enrollee at a rate similar to the rate negotiated by the managed care organization with similar providers of care for similar services.

''(f) PROHIBITIONS.—A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage with a managed care organization under the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to enrollees to encourage such enrollees to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending physician because such physician provided care to an enrollee in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to an attending physician to induce such physician to provide care to an enrollee in a manner inconsistent with this section.

''(g) RULES OF CONSTRUCTION.—

''(1) HMO NOT OFFERING BENEFITS.—This section shall not apply with respect to any managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, that does not provide benefits for stays in a continuing care retirement community, skilled nursing facility, or other qualified facility.

''(2) COST-SHARING.—Nothing in this section shall be construed as preventing a managed care organization under a group health plan, or through a health insurance issuer providing health insurance coverage in connection with a group health plan, from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for care in a continuing care facility.

''(h) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

''(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage to the extent that a State law (as defined in section 2723(d)(1)) applies to such coverage and is described in any of the following subparagraphs:

''(A) Such State law requires such coverage to provide for referral to a continuing care retirement community, skilled nursing facility, or other qualified facility in a manner that is more protective of the enrollee than the provisions of this section.

''(B) Such State law expands the range of services or facilities covered under this section and is otherwise more protective of enrollee rights than the provisions of this section.

''(2) CONSTRUCTION.—Section 2723(a)(1) shall not be construed to provide that any requirement of this section applies with respect to health insurance coverage, to the extent that a State law described in paragraph (1) applies to such coverage.

''(i) PENALTIES.—An enrollee may enforce the provisions of this section in an appropriate Federal district court. An action for injunctive relief or damages may be commenced on behalf of the enrollee by the enrollee's legal representative. The court may award reasonable attorneys' fees to the prevailing party. If a beneficiary dies before conclusion of an action under this section, the action may be maintained by a representative of the enrollee's estate.

''(j) DEFINITIONS.—In this section:

''(1) ATTENDING ACUTE CARE PROVIDER.—The term 'attending acute care provider' means anyone licensed or certified under State law to provide health care services who is operating within the scope of such license and who is primarily responsible for the care of the enrollee.

''(2) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means an organization that provides or arranges for the provision of housing and health-related services to an older person under an agreement effective for the life of the person or for a specified period greater than 1 year.

''(3) MANAGED CARE ORGANIZATION.—The term 'managed care organization' means an organization that provides comprehensive health services to enrollees, directly or under contract or other agreement, on a prepayment basis to such individuals. For purposes of this section, the following shall be considered as managed care organizations:

''(A) A Medicare+Choice plan authorized under section 1851(a) of the Social Security Act (42 U.S.C. 1395w–21(a)).

''(B) Any other entity that manages the cost, utilization, and delivery of health care

through the use of predetermined periodic payments to health care providers employed by or under contract or other agreement, directly or indirectly, with the entity.

''(4) OTHER QUALIFIED FACILITY.—The term 'other qualified facility' means any facility that can provide the services required by the enrollee consistent with State and Federal law.

''(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' means a facility that meets the requirements of section 1819 of the Social Security Act (42 U.S.C. 1395i–3).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 2001.

SEC. 124. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

(a) IN GENERAL.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements) is amended—

(1) by redesignating such subpart as subpart 2; and

(2) by adding at the end the following new section:

"SEC. 2753. ENSURING CHOICE FOR CONTINUING CARE.

''The provisions of section 2707 shall apply to health maintenance organization coverage offered by a health insurance issuer in the individual market in the same manner as they apply to such coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2001.

SEC. 125. SENSE OF THE SENATE CONCERNING THE CARE OF OLDER AMERICANS.

It is the sense of the Senate that—

(1) in the coming decade, people who are over the age of 65 will constitute 20 percent or more of the population of the United States;

(2) in the coming decade, the number of people who are over the age of 85 and will most likely need long-term care may double or triple;

(3) the number of persons who are age 65 or older who have difficulty carrying out at least 1 activity of daily living is estimated to increase between the year 2000 and 2024 by 42 percent, or from 5.2 million persons to 7.4 million persons;

(4) women rely on long-term care services for more years than men do since women live longer;

(5) women who are age 65 or older are twice as likely as men who are age 65 or older to have an income of less than $10,000 per year;

(6) long-term care expenses can have a catastrophic effect on families, in that a lifetime of savings may be spent for long-term care expenses for a spouse, parent, or grandparent before such spouse, parent, or grandparent becomes eligible for governmental assistance; and

(7) the Federal Government should be committed to providing benefits that are designed to ensure the physical, emotional, and financial well being of older Americans in the new century.

Subtitle D—Expansion of Home-Based Long-Term Care Services Under the Social Services Block Grant

SEC. 131. RESTORATION OF AUTHORITY TO TRANSFER UP TO 10 PERCENT OF TANF FUNDS TO THE SOCIAL SERVICES BLOCK GRANT.

(a) IN GENERAL.—Section 404(d)(2) of the Social Security Act (42 U.S.C. 604(d)(2)) is amended to read as follows:

''(2) LIMITATION ON AMOUNT TRANSFERABLE TO TITLE XX PROGRAMS.—A State may use not more than 10 percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out State programs pursuant to title XX.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to amounts made available for fiscal year 2001 and each fiscal year thereafter.

SEC. 132. RESTORATION OF FUNDS FOR THE SOCIAL SERVICES BLOCK GRANT.

(a) IN GENERAL.—Section 2003(c)(11) of the Social Security Act (42 U.S.C. 1397b(c)(11)) is amended to read as follows:

''(11) $2,380,000,000 for the fiscal year 2001 and each fiscal year thereafter.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to amounts made available for fiscal year 2001 and each fiscal year thereafter.

SEC. 133. APPROPRIATION OF ADDITIONAL FUNDS FOR EXPANSION OF HOME-BASED LONG-TERM CARE SERVICES.

(a) IN GENERAL.—Section 2003 of the Social Security Act (42 U.S.C. 1397b) is amended by adding at the end the following:

''(d) With respect to any fiscal year in which the amount appropriated to carry out this title equals or exceeds the amount specified in subsection (c) for such fiscal year, an additional amount equal to 10 percent of the amount so appropriated is hereby appropriated for such fiscal year out of any funds in the Treasury not otherwise appropriated. The additional amount appropriated under this subsection shall be allotted among the States and jurisdictions described in subsections (a) and (b) in the same manner as the allotments for such States and jurisdictions are determined under such subsections. Amounts allotted under this subsection shall be used to expand the provision of home-based services for elderly or disabled individuals.''.

TITLE II—SUPPORT AND PLANNING FOR LONG-TERM CARE

Subtitle A—Support and Surveys

SEC. 201. NATIONAL FAMILY CAREGIVER SUPPORT GRANT PROGRAM.

(a) IN-HOME SERVICES.—Part D of title III of the Older Americans Act of 1965 (42 U.S.C. 3030h et seq.) is amended to read as follows:

"PART D—NATIONAL FAMILY CAREGIVER SUPPORT GRANT PROGRAM

"Subpart 1—State Grant Program

"SEC. 341. PROGRAM AUTHORIZED.

''(a) IN GENERAL.—The Assistant Secretary shall award grants to States with State plans approved under section 307, to pay for the Federal share of the cost of carrying out State programs and enable eligible area agencies on aging to provide multifaceted systems of support services for family caregivers and other caregivers who are informal providers of in-home services and community care for older individuals.

''(b) FAMILY CAREGIVER SUPPORT SERVICES.—In providing services under this part, an area agency on aging shall provide support services, including providing—

''(1) information to eligible caregivers about available services;

''(2) assistance to eligible caregivers in gaining access to the services;

''(3) individual counseling, organization of support groups, and caregiver training to eligible caregivers to assist the caregivers in making decisions and solving problems relating to their caregiving roles;

''(4) respite care to enable eligible caregivers to be temporarily relieved from their caregiving responsibilities; and

''(5) supplemental services, on a limited basis, to complement the care provided by eligible caregivers.

''(c) ELIGIBILITY AND PRIORITY.—

''(1) ELIGIBILITY.—In order for a caregiver of an older individual to be eligible to receive services provided by a State program under this part, the State shall—

''(A) find that the caregiver is a caregiver as described in subsection (a); and

''(B) determine that the older individual meets the condition specified in subparagraph (A)(i) of (B) of section 102(28).

''(2) PRIORITY.—In providing the services, the State shall give priority for services to older individuals with greatest social need and greatest economic need, and older individuals providing care and supports to persons with mental retardation and related developmental disabilities (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001) (referred to in this part as 'developmental disabilities')) consistent with

the requirements of section 305(a)(2)(E), and their caregivers.

''(d) COORDINATION WITH SERVICE PROVIDERS.—In carrying out this part, each area agency on aging shall coordinate the activities of the agency with the activities of other community agencies and voluntary organizations providing the types of services described in subsection (b).

''(e) QUALITY STANDARDS AND MECHANISMS AND ACCOUNTABILITY.—

''(1) QUALITY STANDARDS AND MECHANISMS.—The State shall establish standards and mechanisms designed to assure the quality of services provided with assistance made available under this part.

''(2) DATA AND RECORDS.—The State shall collect data and maintain records relating to the State program in a standardized format specified by the Assistant Secretary. The State shall furnish the records to the Assistant Secretary, at such time as the Assistant Secretary may require, in order to enable the Assistant Secretary to monitor State program administration and compliance, and to evaluate and compare the effectiveness of the State programs.

''(3) REPORTS.—The State shall prepare and submit to the Assistant Secretary reports on the

data and records required under paragraph (2), including information on the services funded under this part, and standards and mechanisms by which the quality of the services shall be assured.

''(f) AVAILABILITY OF FUNDS.—

''(1) IN GENERAL.—A State shall use the portion of the State allotment under section 304 that is from amounts appropriated under section 303(d) to carry out the State program under this part.

''(2) USE OF FUNDS FOR ADMINISTRATION OF AREA PLANS.—Amounts made available to a State to carry out the State program under this part may be used, in addition to amounts available in accordance with section 303(c)(1), for costs of administration of area plans.

''(3) FEDERAL SHARE.—

''(A) IN GENERAL.—Notwithstanding section 304(d)(1)(D), the Federal share of the cost of carrying out a State program under this part shall be 75 percent.

''(B) NON-FEDERAL SHARE.—The non-Federal share of the costs shall be provided from State and local sources.

"SEC. 342. MAINTENANCE OF EFFORT.

''Funds made available under this part shall supplement, and not supplant, any Federal, State, or local funds expended by a State or unit of general purpose local government (including an area agency on aging) to provide services described in section 341(b).

"Subpart 2—National Innovation Programs

"SEC. 346. INNOVATION GRANT PROGRAM.

''(a) IN GENERAL.—The Assistant Secretary shall carry out a program for making grants to appropriate entities on a competitive basis to foster the development and testing of new approaches to—

''(1) sustaining the efforts of family caregivers and other informal caregivers of older individuals;

''(2) serving the needs of particular groups of caregivers of older individuals, including minority caregivers and distant caregivers; and

''(3) linking family support programs with the State entity or agency that administers or funds programs for persons with mental retardation or related developmental disabilities and their families.

''(b) EVALUATION AND DISSEMINATION OF RESULTS.—The Assistant Secretary shall provide for evaluation of the effectiveness of programs and activities funded with grants made under this section, and for dissemination to States of descriptions and evaluations of the pro-

grams and activities, to enable States to incorporate successful approaches into their individual State programs under this part.

''(c) AVAILABILITY OF FUNDS.—

''(1) IN GENERAL.—The Assistance Secretary shall reserve not more than 10 percent of the amount appropriated under section 303(d) for a fiscal year to carry out the program of the Assistant Secretary under this section.

''(2) NATIVE AMERICAN PROGRAMS AND ACTIVITIES.—Twenty percent of the amount reserved under paragraph (1) shall be available for programs and activities under this section for caregivers serving Indians and Native Hawaiians, as defined in section 625.

''SEC. 347. ACTIVITIES OF NATIONAL SIGNIFICANCE.

''(a) IN GENERAL.—The Assistant Secretary shall, directly or by grant or contract, carry out activities of national significance to promote quality and continuous improvement in the support services provided to family caregivers and other informal caregivers of older individuals, through program evaluation, training, technical assistance, and research.

''(b) AVAILABILITY OF FUNDS.—The Assistant Secretary shall reserve not more than 2 percent of the amount

appropriated under section 303(d) to carry out the activities under this section.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 303(d) of the Older Americans Act of 1965 (42 U.S.C. 3032(d)) is amended to read as follows:

''(d) There are authorized to be appropriated $125,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 through 2005, to carry out part D (relating to the national family caregiver support grant program).''.

(c) CONFORMING AMENDMENT.—

(1) TRANSFER OF DEFINITION.—Section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002) is amended by adding at the end the following:

''(45) The term 'in-home services' includes—

''(A) services of homemakers and home health aides;

''(B) visiting and telephone reassurance;

''(C) chore maintenance;

''(D) in-home respite care for families, and adult day care as a respite service for families;

''(E) minor modification of homes that is necessary to facilitate the ability of older individuals to remain at home, that is not available

under another program (other than a program carried out under this Act);

''(F) personal care services; and

''(G) other in-home services as defined—

''(i) by the State agency in the State plan submitted in accordance with section 307; and

''(ii) by the area agency on aging in the area plan submitted in accordance with section 306.''.

(2) REFERENCES.—

(A) Section 307(a)(10) of such Act (42 U.S.C. 3027(a)(10)) is amended by striking ''(as defined in section 342)''.

(B) Sections 382 and 383 of such Act (42 U.S.C. 3030q, 3030r) are repealed.

(C) Section 429F(a) of such Act (42 U.S.C. 30305n) is amended—

(i) by striking paragraph (2); and

(ii) by striking ''this section:'' and all that follows through ''The term'' and inserting ''this section, the term''.

SEC. 202. COMMUNITY SURVEY.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a multi-city and county sur-

vey to determine if communities are elder-ready, or prepared to accommodate the needs of aging baby boomers.

(b) PURPOSE.—The Secretary shall conduct the survey described in subsection (a) to determine if cities and counties across the United States are prepared to accommodate the needs of aging baby boomers regarding housing, safety, health care, transportation, and access to community services and leisure activities.

(c) TITLE OF SURVEY.—The survey described in subsection (a) shall be entitled ''Is Your Community Elder-Ready?''.

(d) REPORT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall prepare and submit a report to the appropriate committees of Congress and cities and counties that the Secretary determines should receive such report regarding the findings of such survey described in subsection (a).

(2) CONTENT.—The report described in paragraph (1) shall identify existing resources and challenging areas for cities or counties to resolve or address in order for such cities or counties to become elder ready. Such report shall also include recommendations, action plans, and timetables for dealing with deficiencies.

Subtitle B—Education and Studies

SEC. 211. LONG-TERM CARE COVERAGE EDUCATIONAL CAMPAIGN.

(a) IN GENERAL.—The Secretary of Labor, in conjunction with the Secretary of Health and Human Services and the Administrator of the Small Business Administration, shall establish and carry out a national public information campaign to provide employers and employees with information concerning the benefits of long-term health care coverage.

(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out subsection (a).

SEC. 212. GAO REPORT ON LONG-TERM CARE.

Not later than 24 months after the date of enactment of this Act, the Comptroller General of the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning the long-term care programs of the Veterans Administration, including—

(1) a description of the long-term care services provided under such programs;

(2) data concerning the utilization and financing of such programs;

(3) information concerning the quality assurance processes used under such programs;

(4) a description of any recent modifications to such programs; and

(5) a description of the management challenges faced in administering such programs.

SEC. 213. AGING STUDY AND REPORT.

(a) STUDIES.—The Secretary of Health and Human Services shall conduct not less than 1 study to determine—

(1) activities or programs to conduct to improve the quality of life for the elderly;

(2) measures to be taken to prevent or delay the onset of age-related functional decline and disease and disability among the elderly;

(3) whether medicare health promotion and disease prevention benefits reduce or delay the need by seniors for long-term care services; and

(4) the manner in which the aging of the population in the United States will impact the administration and solvency of Federal programs, such as programs under titles XVIII, XIX, and XX of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq., and 1397 et seq.) and programs established

under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.).

(b) REPORT.—Not later than January 1, 2003, the Secretary of Health and Human Services shall prepare and submit to Congress a report regarding the study described in subsection (a).

○